Petitions Received Regarding North Carolina State Medical Facilities Plans 2005 through 2009

Attached are petitions/related material from the following entities:

Attachment A – Proposed 2009 Plan – Granville –Vance Home Health Agency.

Attachment B – Proposed 2008 Plan – Personal Home Care of NC.

Attachment C - Proposed 2007 Plan (March) – Personal Home Care of NC.

Attachment D – Proposed 2007 Plan (Summer) – Personal Home Care of NC.

Attachment E – Proposed 2005 Plan - TarHeel Home Healthcare/Capital Health Management Group. Included are other comments received regarding the Proposed 2005 Plan.

ATTACHMENT A

Granville-Vance District Home Health Agency
W. Rodwell Drake, Jr., M.D., Director
125 Charles Rollins Road
Henderson, North Carolina 27536

(252) 492-5831
FAX (252) 492-3613

1-800-682-3887

February 25, 2008

Petition for Amendment and Revision to the State Medical Facilities Plan

W. Rodwell Drake, Jr., MD
Granville-Vance District Health Director
rdrake@gvdhd.org
252-492-7915 or 919-693-2144

North Carolina Division of Health Service Regulations
Medical Facilities Planning Section
2714 Mail Service Center
Raleigh, NC 27699-2714

Granville-Vance Home Health Agency, a division of the Granville-Vance District Health Department, is requesting a policy amendment to allow home health agencies that operate within a multi-area District Health Department to have option of having their office located in the county which best serves both them and their clients. The present policy does not properly address home health agencies operating in Health Districts.

Our Agency changed its physical location in January 2007 from Granville County to Vance County because of need for space, both in home health and in the health department. This has proven to be a cost-effective, efficient move for both and has not affected access to client care. Since care is provided in the home, it is not necessarily dependent upon office location and in fact, in our case we can just as easily provide services from our current location as well as actually increase services in Granville and Vance Counties because of more appropriate office space and increased efficiency. Our location is in the former Vance County Mental Health facility and was offered to us rent free. We are located 3.5 miles from the Granville County line and only 10 minutes from our former office.

We continue to maintain the same services in Granville County as we have for the last 34 years. The number of patients served in Granville County is twice the number served in Vance County and over the thirteen months since our location change the ratio has remained the same. I strongly recommend that you amend the present policy to allow District Health Department home health agencies to be considered located in each county served regardless of physical location.

We notified DFS of our plans and address change prior to our move which, of course, was no problem because we are licensed to provide services in both counties. Not until thirteen months later were we informed of the possibility that our move might precipitate a "determination of need" which could allow another home health agency to locate in Granville County. Since no change in "need" was created by our move it would seem appropriate to amend the policy which in this case does not seem to be very sensible. I appreciate your consideration of this petition.

W. Rodwell Drake, Jr., MD
Granville-Vance District Health Director

Petition – Personal Home Care of NC
Regarding the Proposed 2008 State Medical Facilities Plan

Attached are:

1. Agency Report on the Petition.

2. Petition.

3. Comments from March 7, 2007, Public Hearing

4. Comment from Association for Home & Hospice Care of North Carolina

AGENCY Report:

Proposed 2008 Plan

- Notes related to **Home Health Petition** from **Personal Home Care of NC, LLC**

Request

Personal Home Care of NC, LLC submitted a Petition requesting:

" Increase the planning horizon by three years, rather than one.
Include a mechanism to permit adjustment for chronically underused capacity for home health agencies."

Background Information

The home health need methodology projects future need based on trends in historical data, including the "Average Annual Rate of Change in Number of Home Health Patients" over the previous three years and the "Average Annual Rate of Change in Use Rates per 1000 Population" over the previous three years. Average annual rates of change are compiled based on "Council of Governments (COG)" regions.

Patient origin data used in the Plan is compiled from Home Health Agency Annual Data Supplements to License Applications as submitted to the Division of Facility Services. The data supplements request data for a twelve month period using a start date of either July, August, September or October. The methodology aggregates patient origin data by four age groups, 0-17, 18-64, 65-74 and over 75.

The methodology utilized in development of the State Medical Facilities Plan does not project future need based on the number of home health agencies in any given county or on the capacity of existing agencies. Rather, it projects need based on the number of patients served during the reporting years indicated in the plan. In essence, if existing agencies keep pace with the projected number of persons who may need home health services, there would not be a need determination. However, if they do not keep pace, there may be a need determination allowing an opportunity for a new home health agency or office.

If there were to be a need determination in the 2008 Plan, anyone can apply. Therefore, there is no guarantee that the petitioner would be the approved applicant.

Staff provided the petition for comment to the Association for Home and Hospice Care of North Carolina. Written comments have not be received as of the date this report was printed.

ANALYSIS OF PETITION

The petition states that a one year planning horizon is not long enough.

The 2007 Plan states, the target for projections should be one year beyond the Plan Year, to allow time for completion of the Certificate of Need review cycles and for staffing of new agencies or offices. The planning horizon for home health has been one year since the 1994 Plan. In the 1993 Plan the projections were for the Plan year. As noted in the 1993 Plan,

usually no capital construction is required to initiate a new home health agency or office. This distinction is made between home health services and other services such as nursing homes and adult care homes where construction is frequently required for additions or development of new facilities. The planning horizon for nursing home and adult care home need determinations is three years.

Another home care related service for which need determinations are made is hospice home care. The planning horizon for this service is the same as for home health, one year beyond the Plan year. It is interesting to note that numerous new hospice home care agency offices were able to be established in 2005 preceding the effective date of changes in the hospice home care Certificare of Need legislation.

Based on current population estimates and projections, utilization data, and methodology, there would not be a need determination in any county in the State in the Proposed 2008 Plan. There are three counties with projected deficits greater than 100; namely, Brunswick, Cumberland and Union counties. To effect a three year planning horizon, steps 5 and 8 of the methodology would be modified to reflect advancing years by 5 rather than 3 and using projected 2011 population rather than 2009 population figures. The following table indicates the effect of using a three year planning horizon versus one year on the deficits projected for these counties.

County	Proposed 2008 – One Year Horizon	Proposed 2008 – Three Year Horizon
Brunswick	-126 deficit	-247 deficit
Cumberland	-111 deficit	-232 deficit
Union	-167 deficit	-322 deficit

With regard to Mecklenburg County the projected surplus of 249 would be reduced to 26 if a three year horizon were used and Cabarrus county would show a deficit of 38 rather than 0.

Agency Recommendation

The Agency supports the home health standard methodology. The Agency recommends that the petition be denied.

Petition to the State Health Coordinating Council Regarding the Home Health Methodology and Policies For the 2008 State Medical Facilities Plan

Petitioner:
Personal Home Care of NC, LLC
4401 Colwick Road
Suite 711
Charlotte, NC 28211

Contact:
Ivans Belovs
Personal Home Care of NC, LLC
704-975-5253

PETITION

STATEMENT OF REQUESTED CHANGE

Personal Home Care (PHC) of NC, LLC requests the following changes in the methodology and policies for the 2008 State Medical Facilities Plan.

- Increase the planning horizon by three years, rather than one.
- Include a mechanism to permit adjustment for chronically underused capacity for home health agencies.

REASONS FOR THE PROPOSED CHANGES

Timing of the Batch Cycles

By using a target planning year that is advanced by only one year from the Plan year, the Plan makes no allowance for the batch cycles. For example, the one home health agency included in the 2007 State Medical Facilities Plan has a batch cycle that begins September 1, 2007. The deadline for completing review is January 28, 2008. The appeal period will extend to February 28, 2008. In the best of circumstances, by the time a new applicant mobilizes and gets all of its required clearances from Medicare and State Licensure, it will not be fully operational until November or December 2008. That is virtually 2009. One year, which would be 2008, is clearly not a long enough planning horizon.

The methodology itself presumes that it will take fully three, and possibly more, years for a new agency to become fully operational. Note on page 206 that the 400 patient placeholder remains in the Plan for "three annual Plans following certification of the agencies."

The methodology uses three years retrospectively to get an average annual rate of change in use of home health agency services.

A planning horizon of three years would clearly be more compatible with the rest of the methodology.

Chronically underutilized facilities

The use of historical use rates to forecast future capacity of existing providers is already designed to favor the status quo. The underlying assumption of the methodology is that – if services grew for the past three years, existing agencies will be able to grow at the same rate for another year. There is no basis in reality for this assumption.

Moreover, the practice of grouping agencies into Council of Government regions for purposes of forecasting future demand masks need. Fast growing communities like Mecklenburg is permitted to grow slower than adjacent Gaston County, where the supply and performance of home health agencies is clearly more efficient. Gaston use rates are as much as 40 percent higher than Mecklenburg.

The methodology tends to mask this and as a result under reports the number of home health agencies needed statewide. For example, the following data are taken from Table 12C on page 241 of the 2007 SMFP. The Plan shows a need for only one agency. In fact, the shortfall in the Plan is sufficient to justify more than 5 agencies.

Pop Adjustment for Agencies under Development	895
Adjusted Potential Persons Served	203703
Projected Utilization	205896
Persons Unserved	2193
Agencies needed at 400 each	5.4825
Agencies in the 2007 Plan	1

Population Growth and Aging

For illustration, we have used the greater Mecklenburg area, including Mecklenburg, Union and Cabarrus Counties. This is the area we serve. It is experiencing rapid population growth, growing much faster than the state of North Carolina. In fact, according to the State Demographer, between 2004 and 2005 the Mecklenburg, Cabarrus, Union County area population increased 131 percent faster than the State average. The Demographer predicts that, even though it may slow down, a strong growth trend will continue through 2010.

Annual Population Increase

	2005	2006	2007	2008	2009
Greater Mecklenburg	3.8%	3.2%	2.8%	2.6%	2.6%
North Carolina	1.7%	1.7%	1.6%	1.5%	1.5%
Ratio of GM to NC	231.3%	188.0%	177.4%	171.1%	168.7%

Source: http://demog.state.nc.us/ (last updated June 12, 2006)

The area is also aging rapidly. While the total population of Mecklenburg, Union, and Cabarrus Counties is expected to increase 30 percent between 2000 and 2010, the segment of population 60 years of age and older is expected to increase by 44 percent according to the North Carolina Office of State Budget and Management.1

Disease and disability increase with age. Proper implementation and management of home health services can keep older people out of nursing homes and save millions in healthcare dollars. Data from the "Home Health Agency 2006 Annual Data Supplements" indicated 4.5 percent more home health patients statewide were served during 2005 than in 2004 and that use rates are rising. With the regional increase in number and age of the population in the greater Mecklenburg area, the regional need for in-home health services will only grow. Yet the 2007 State Medical Facilities Plan does not show a need for a home health agency in Region F. Reasons include: lower forecasts of demand growth in Mecklenburg County, the one year planning horizon and a placeholder adjustment for a Mecklenburg CON awarded in 2005 that continues to be undeveloped. The placeholder will occur again in 2008, because the agency has again not yet developed.

The methodology is complex. That is why we have proposed a very simple adjustment. : Moving the planning horizon forward by two more years, so that the methodology is internally consistent.

[1] http://demog.state.nc.us/ (last updated June 12, 2006) NC population over 60 in 2000 was 1,292,638; in 2010, it will be 1,670,296.

Russian Population

You have heard me before speak about the Russian population. They kept increasing since I first visited you in winter 2006. We now have more than 400 patients under our care in our personal home care and durable medical equipment services. Many of these patients could benefit from Medicare home health agency services. We cannot offer this service, because we cannot apply for a license.

As noted in the attached August 2007 article from *USA Today*, language interpretation is a major problem in American Health care. When provider resources are already stretched, finding time for translation is even more problematic. Differences in age adjusted use rates among North Carolina counties suggest that in many North Carolina communities provider resources are at a premium.

It is easy to understand why it would be easy to overlook a population group that does not speak English. The existing agencies especially do not have the time or resources to learn Russian. Russian is a VERY difficult language for English-speakers to learn. It uses a different alphabet and different idiomatic structures. The culture is different and direct translation does not always communicate the intended meaning.

There are large groups of non-English speakers in North Carolina. Measuring the number of residents in these communities is very difficult. Census data are by the Bureau's admission, unreliable. For example, there is no check-off on the census form to indicate Russian-speaking. At best, the census estimates ancestry and that count is incomplete. To estimate the size of the Russian-speaking community, we have approached city and county governments, the Census internet sites, private companies that specialize in demographic profiles such as Migliara Kaplan, and refugees' resettlement agencies. From each we received the same answer, "There are no reliable data." The US Census report of 4,109 Russian-speaking residents in North Carolina in 2000 is clearly an underestimate. According to Mr. Anton at www.russiancarolina.net there are probably between 10,000 and 30,000 Russians in the Charlotte area.[2] Mecklenburg's Russian language newspaper, Panorama Charlotte, which is printed in Russian, distributes over 10,000 copies monthly. Each of these is shared at least five times, putting the estimate at 50,000 people. Church attendance at Russian speaking services in Charlotte alone is estimated at 10,000 weekly. Russian businesses in Charlotte alone number 73. As a proxy measure of the breadth of the Russian speaking population, we have assembled the attached list of Russian businesses, Russian churches, and letters from the Mecklenburg County and Union County Community Alternative Programs (CAP). The latter agencies contract with Personal Home Care of NC to provide in-home aide care to Medicaid beneficiaries. Many of the Russian speaking community have migrated to Union County where housing is less expensive. Their family culture supports in-home healthcare as opposed to nursing home care for the elders.

[2] Anton. www.russiancarolina.net. June 19, 2006.

Staff at Personal Home Care of NC is acutely aware of the Russian presence in large numbers, because we serve them. We are part of them. We are a licensed North Carolina home care provider. Today, we are providing in-home nursing visits to these people at no charge, because we cannot offer the Medicare benefit. At the same time, the people we serve cannot get full care from existing home health agencies.

I can tell you personal stories of people who have died without care. I can tell you about the people who come into our DME store for help with incontinence supplies. Some of them are not Russian speaking. We can sell them supplies, but we cannot provide this most difficult of home nursing services, not because we cannot find the staff, but because there is no need in the Plan.

Need for Home Health in the non-English Speaking

Home Health is a Medicare and Medicaid core service, but home health agency care requires communication between patient and caregiver. All of the services occur in the patient's home, where a caregiver is on his/her own to make judgments and leave instructions. The premise of home health agency care is that the care provider can instruct the patient and/or family caregiver in continued maintenance of the care regimen after the home health agency eligibility expires. When language is a barrier for both provider and patient, this cannot occur.

Last year, I discussed the story of Ivan and his wife, Luda, his caregiver. Ivan finally died months after he and Luda struggled in the prison of their language isolation, with their dignity compromised.

We see this story often, because we are in touch with immigrant families through our contacts with Medicaid Community Alternatives Programs for Disabled Adults (CAP) and now through our Durable Medical Equipment store.

Today, Personal Home Care of North Carolina has 90 in-home aides, who are providing care to more than 400 home bound patients, many of whom would qualify for Medicare services. However, Personal Home Care of NC cannot provide Medicare "home health agency care" because we do not have a home health agency license. Our license limits us to home care services through Medicaid's Personal Care and CAP programs. Mecklenburg's CAP agency continues to refer the patients to Personal Home Care of NC, because Personal Home Care of NC is the only Russian-speaking service in the area. Personal Home Care of NC is providing nursing service to all of them without getting compensated, because these patients have no other care alternative. This is not sustainable for long. Without a home health agency, we at PHC cannot provide a full continuum of care for these patients. Similarly, few agencies want to take the extra time associated with care for incontinent patients.

The Mecklenburg CAP nursing Supervisor reported last year that each week she finds many patients who cannot get served by existing home health agencies. Most need both home health agency and in-home aide care, which few providers offer. The Russians, who represent 12 percent of the Mecklenburg County CAP case load, are a particular problem because of the language barrier and the lack of interpreters.

We know that we are not the only ethnic group with an issue, or indeed not the only people who can tell you stories about unmet home health need. North Carolina is ready for more home health agency resources.

Home health agency services are intended to be of short duration, usually one month or less, with each visit lasting about one hour. They are built on the premise that health care providers will involve family caregivers in an education program that involves training in continued care of the patient. When language is a barrier, this critical service element cannot occur. As a result, the patient usually drops out of the service, frustrated by both sides' inability to communicate. Consequently, patients are not getting services to which they are entitled by law.

Prior to submitting this application, we, Personal Home Care of NC, checked with every home health agency that serves Mecklenburg County. Not one had a Russian-speaking nurse on the payroll. We have been trying to establish alternatives with existing agencies or to purchase an agency since our 2006 petitions to the SHCC. Last year, the SHCC suggested that we try meeting with Mecklenburg County Home health agencies. The Home Health association was instrumental in arranging a meeting on November 28, 2006. Agency representatives were pleasant and engaging and expressed some passing interest. However, to date, not one of those agencies followed up or responded to our requests for follow up meetings.

Contrary to information we had been given by the Long Term Care Committee last year, we have learned that there are no home health agencies available to purchase. We followed up on discussions with the North Carolina Association for Home Health and Hospice Care and with Gary Massey of LarsonAllen in Charlotte, in regards to acquiring an existing agency or establishing an outsourcing contract.

Carolinas Medical Center and Presbyterian do have contracts with interpreter services. The interpreter service as an alternative is better than nothing. However, at $4 per minute, these interpreter services are not affordable for the entire 50 minute visit. They alone would cost more than Medicare will pay for the visit.

The 2007 State Medical Facilities Plan shows a deficit of 57 patients in Mecklenburg County, 45 in Cabarrus County and 210 patients in Union County for a total of 312 patients. Home Health Region F already shows a deficit of 288 patients. Even with the methodology set at one year, Region F would show a need for a new agency, but a 400-patient placeholder that has been in the Plan for two years eliminates the need. The full Region F need for the year 2008 – next year – is 688 patients.

However, the true problem is not just Russian speaking people, or even the non-English speaking people, as many have observed. The true problem is the length of time it takes to start a new agency, the rate at which the North Carolina population is growing and the need to keep resources paced with growth in our population.

ADVERSE EFFECTS ON PROVIDERS AND CONSUMERS OF NOT MAKING THE REQUESTED CHANGE

Expanding Health Care Services to the Medically Underserved is one of the three basic principles of the State Medical Facilities Plan.

Without more home health agency capacity, much of the state will remain underserved in home health. From one Council of Governments region to another within the state, the use rates differ as much as 100 percent within in the same age groups. Within some Regions, the use rates differ by as much as 50 percent.

In the fastest growing parts of the state, service shortages are more likely to result in difficult populations like the Russians and the incontinent not getting served, because the resources are consumed by persons who are easier to serve.

Not to act is to deprive a large population, whose members wish to stay out of institutions, of the care needed to support them at home. A day of home health agency service is far less expensive than a day in a skilled nursing care facility. More importantly, the home health agency care regimen is designed to make the patient independent in a month or two, whereas, once placed in a nursing home, a patient tends to stay about three years.

Delay will be costly to the state and to patients. If the methodology does not change the 2008 State Medical Facilities Plan, will plan for a need in 2009, and service benefits will not really occur until 2010, at best. Two hundred people admitted to nursing homes during the delay would not likely be discharged for three years.

ALTERNATIVES TO THE REQUESTED CHANGE CONSIDERED AND REJECTED

Personal Home Care of NC, LLC considered several alternatives, including: 1) status quo; 2) Purchasing a home health agency; 3) subcontracting with an existing home health agency to specialize in provision of home health services to Russian-speakers; and 4) this petition. This petition is the result of three years of unsuccessfully trying the other three alternatives.

We are living the status quo. Patients are calling Personal Home Care of NC when they have a medication or wound care crisis. Unwilling to cause families and patients undue suffering, Personal Home Care of NC has been providing free home visits to those in most dire need. This is not sustainable. Personal Home Care of NC has tried getting the patients into area home health agencies, only to have the service fail because of the communication problems. Moreover, leaving eligible people without service is unjust. Many of the people who cannot get home care are screened out by existing agencies, because the agencies do not offer the less profitable in-home aide service that these patients need as a complementary benefit.

Purchasing an agency is not possible. No agencies or suboffices are for sale in North Carolina. Working a subcontract or joint venture with other agencies to hire Russian speaking staff is a very compelling concept. We have attended those meetings, offered our services, and nothing happened, not even a returned phone call.

NON-DUPLICATION OF SERVICES

This proposed change will only produce internal consistency in the Home Health agency methodology. Hence it will not involve duplication of services. It will adjust the need forecast to the date when services will realistically be available.

This proposal responds to a deficit identified in the current home health agency methodology.

CONCLUSION

The North Carolina State Health Coordination Council and the Medical Facilities Planning Section perform an outstanding service in developing a State Medical Facilities Plan that strives to properly and fairly address the healthcare needs of the residents of North Carolina. Advancing the planning year from one to three years will provide internal consistency in the methodology; it will be an easy change, requiring no extra staff time, and it will pace resources with population growth.

F:\Client Projects\PersonalCareNC\PetitionMethod2007\PetitionHH.doc

Language barriers plague hospitals

Posted 7/20/2006 12:27 AM ET

Enlarge By Charlie Riedel, AP

Medical interpreter Bobbi Daren, left, translates instructions from Linda Fierst, right, into Spanish for Monica Salcido at Providence Medical Center in Kansas City, Kan.

By Elizabeth Weise, USA TODAY

Many hospital patients who have a limited ability to speak English and who need a translator don't get one, which puts them at risk for poor and sometimes life-threatening medical care, an analysis in today's *New England Journal of Medicine* says.

From 1990 to 2000, the number of residents with limited English proficiency grew by 7 million, to 21 million, or 8.1% of the population, according to U.S. Census figures. Yet, one study showed that no interpreter was used in 46% of emergency department cases involving such patients, says Glenn Flores, an expert on language barriers in health care who based his conclusions on his own studies and those done by other researchers.

Only 23% of teaching hospitals offer physicians training in how to work with an interpreter, he says. "Lack of interpreters translates into impaired health status, lower likelihood of being given a follow-up appointment, greater risk of hospital admissions and more drug complications," says Flores, a professor at the Medical College of Wisconsin-Milwaukee.

IN OTHER WORDS: Demand surges for translators at medical facilities

He cites the case of a 7-year-old girl with an ear infection whose mother was told by a poorly trained interpreter to put the oral antibiotic in her daughter's ears. In another case, a 2-year-old who fell off her tricycle was taken from her mother by social workers because a doctor misinterpreted the Spanish words "*Se pegó*" to mean "I hit her" rather than "She hit herself," Flores says.

And in a case that cost a Florida hospital a $71 million malpractice settlement, he says, an 18-year-old who said he was *intoxicado*, which can mean nauseated, spent 36 hours being treated for a drug overdose before doctors realized he had a brain aneurysm.

Under Title VI of the Civil Rights Act of 1964, the denial or delay of medical care because of language barriers is discrimination. Any medical facility that receives Medicaid or Medicare must provide language assistance to patients with limited English proficiency.

The American Medical Association says making health care providers responsible for the cost of an interpreter is unfair. An AMA survey found that the cost of hiring an interpreter varied from $30 to $400 an hour depending on language and skill level, significantly higher than the payment for a Medicaid office visit, which in many states is from $30 to $50.

California passed legislation in 2003 requiring health care providers to make interpreters available to those who need them, says Cindy Ehnes of the state's Department of Managed Health Care. Otherwise, she says, quality care is clearly "difficult if not impossible."

Posted 7/20/2006 12:27 AM ET

Public Hearing – March 7, 2007

Comments – Ivans Belovs, Personal Home Care of NC

Thank you. My name is Ivans Belovs. As many of you know, I am involved with Personal Home Care of North Carolina agency in Charlotte. We are providing personal home care services for Medicaid so far. We have prepared a formal petition to submit today asking for a change in the Home Health Methodology and Policy to make it internally consistent and make it possible for new home health agencies to be available when people need them. As many of you know, we submitted a similar petition a year ago. Unfortunately it was turned down. We are working hard, especially with Mr. Rogers. I want to thank Mr. Rogers and the Association for Home and Hospice Care for trying to help. Unfortunately nothing has gone through. We've had several meetings with largest home health agencies in Charlotte. It doesn't work for us. They are not interested in doing business with us. We've tried to buy some CON's to build up a home health agency for Russian speaking population in the Charlotte area. Unfortunately none have been for sale. As I mentioned in the last petition there is a large Russian population, nearly 40,000 in the Charlotte and surrounding area. They still need home health services. Cannot receive because of language barrier. The two largest home health agencies in the area provide translator services and they have one translator between both Presbyterian and Carolinas Medical Center. Basically, it is not enough. Our agency receives lots of calls during day and sometimes nighttime and we stop by to help people to translate. The need is still there. We also found out its not only Russian speaking but other minorities have similar circumstances not only in Charlotte but all of North Carolina. The proposed change in the methodology is basically very simple. It will not require extra staff effort. It should put more agencies where the population is growing. We looked at the plan and find that the use rates vary as much as 200% from County to County in the same age groups. That tells us something's wrong. More accurate numbers can be found in the petition. Whatever you do, just put more agencies in the plan in the fast growing communities such as the Charlotte area and Triangle area. This will serve better for all the citizens of North Carolina. Thank you very much.

DRAFT 3.28.07

Association for
Home & Hospice Care
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TO: Floyd Cogley, MFP Section

FROM: Tim Rogers, CEO

Date: May 15, 2007

Re: Comments for SHCC- LTC/BH Meeting

Please accept the following comments and observations regarding the LTC and Behavioral Committee Report:

NURSING HOMES: Comment on Comment of Ms. Camelia Smith regarding more NH beds for Vent patients

1. Ventilator dependent patients are very prone to infection and progress better at home whenever possible - this is well documented in health literature. Medicaid PDN program is one option.

2. The current staffing levels in NC nursing homes do not seem to support this acute level of patient. In reviewing the Division of Facility Services certification survey outcomes on the CMS nursing home compare website: it appears that all but one of the facilities mentioned in the petition exceeded the average number of nursing home deficiencies in NC (6) and the nation (8) http://www.cms.hhs.gov/NursingHomeQualityInits/

If current, well established nursing homes with respiratory beds are unable to improve outcomes to the NC average number of deficiencies, 6, then establishing more beds of this type does not necessarily seem to be the answer. The acuity level of this type of patient may in fact hinder the facility from improving their outcomes as scarce resources and staffing levels and staffing time may already be stretched far too thin.

Elizabeth Place

29 Health Deficiencies 4 Fire Safety Deficiencies	Nursing Staff time per resident per day 1 hour 20 minutes	Aide time per resident per day 2 hours 17 minutes
	Total Number of Residents: 102	

Oak Summit Winston Salem

11 Health Deficiencies 2 Fire Safety Deficiencies	Nursing staff time per resident per day 1 hour 51 minutes	Aide time per resident per day 2 hours 36 minutes
	Total Number of Residents: 155	

Valley Nursing Center Taylorsville

14 Health Deficiencies 1 Fire Safety Deficiency	Nursing Staff time per resident per day 1 hour 11 minutes	Aide time per resident per day 2 hours 4 minutes
	Total Number of Residents: 157	

Pungo District Hospital

11 Health Deficiencies 0 Fire Safety Deficiencies	Staffing time Not Available - Your State Survey Agency may have the staffing information for this facility.	Staffing Time Not Available - Your State Survey Agency may have the staffing information for this facility.
	Total Number of Residents: 8	

Blue Ridge Health Center

6 Health Deficiencies 10 Fire Safety Deficiencies	Nursing Staff time per resident per day 1 hour 56 minutes	Aide time per resident per day 2 hours 9 minutes
	Total Number of Residents: 124	

HOME HEALTH: Comments on Personal Home Care (Charlotte NC) petition

This petition is being submitted by a licensed home care agency located in Charlotte NC trying to become Medicare certified in order to serve a different group of patients –Medicare home health with skilled services unlike the home care patients they currently serve which are personal care services (unskilled).

This petitioner has tried on two previous occasions to have the SHCC adjust or modify methodology and in both cases, the MFPS staff has recommended denial and so has the SHCC. Once again, the MFPS staff has recommended denial and the AHHC of North Carolina concurs.

After the last SHHC meeting, AHHC initiated a discussion group between the petitioner and existing Medicare home health agencies that serve Mecklenburg County. AHHC continues to be sympathetic and supportive of this agency's intent on securing service for its Russian minority patients.

AHHC once again believes increasing the Planning horizon by three years (as suggested by Petitioner) versus the current one is problematic and unnecessary. The nursing home and adult care home planning is three years because these are facility-based services that require lengthy construction time, unlike a home health agency that does not.

AHHC is recommending that the SHCC re-convene its Home Health Methodology Task Force which was already discussed for the coming year. This Task Force will examine existing trends in Medicare home health reimbursement (which is scheduled for reform according to latest Federal Register) as well as the threshold and methodology factors.

In agreement with staff, AHHC requests the petition be denied.

HOSPICE SERVICES:

For reasons to be discussed at the meeting, AHHC along with the Carolina Center for Hospice support an adjusted no new need for hospice home care programs for one year.

The petition regarding Southeastern Medical Center and a change in hospice inpatient methodology is problematic. In agreement with the Carolinas Center for Hospice, we feel the two trade associations should re-convene a hospice task force along with the Division and examine possible changes in this methodology. Any recommendations for changes would be supportive for the 2009 Plan not for the current one. AHHC feels the petition should be denied.